Commonwealth of Virginia
Department of Social Services
APPLICATION FOR BENEFITS

GENERAL INFORMATION

With this application, you can apply for one or more of the following assistance programs. Refer to the fold-out page for instructions.

- Food Stamps
- Temporary Assistance for Needy Families (TANF)
- General Relief
- Emergency Assistance
- Auxiliary Grants
- Refugee Cash and Medical Assistance
- Medical Assistance:
  - Medicaid
  - Plan First
  - FAMIS, FAMIS PLUS, FAMIS MOMS
  - State and Local Hospitalization

Individuals who have a disability or who have difficulty with English may receive extra help to make sure they get assistance or services they are eligible to receive.

VERIFICATION AND USE OF INFORMATION

The information that you give may be matched against Federal, State and local records, including the Virginia Employment Commission and the Department of Motor Vehicles to determine if it is complete, accurate, and truthful. In addition, your Social Security Number (SSN) will be used to verify your identity, prevent receipt of benefits from more than one social services agency at the same time, and make required program changes.

The Income and Eligibility Verification System (IEVS) may also be used to verify information. This system uses your SSN to verify wages and salary, unemployment benefits, and unearned income by using records from the Internal Revenue Service and the Social Security Administration. The State Verification Exchange System (SVES) uses your SSN to verify your receipt of Social Security and Supplemental Security Income (SSI) benefits. It is also used to verify quarters of coverage under Social Security, if you are an alien. In addition, the U.S. Citizenship and Immigration Services (USCIS) will be used to verify the status of aliens. Any difference between the information you give and these records will be investigated. Information from these records may affect your eligibility and benefit amount. If a food stamp claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

032-03-0824-22-eng (7/08)

SPECIAL INFORMATION FOR FOOD STAMP APPLICANTS

You may apply for Food Stamps by leaving a completed Application for Benefits at the agency or by leaving a partially completed Application with at least your name, address, and signature, or by tearing off and leaving this half-sheet with your name, address, and signature. **You must complete the rest of this Application before your eligibility can be determined**.

You must also be interviewed. Under certain hardships, you may be interviewed by telephone. You may turn in your application before you are interviewed. This is important because if you are eligible for the month in which you apply, your food stamp amount will be based on the date you actually turn in your application.

EXPEDITED SERVICE FOR FOOD STAMPS

Your household may qualify for Expedited Service and receive food stamps within 7 days if you are eligible and if your gross monthly income is less than $150 and liquid resources are $100 or less; or your monthly shelter bills are higher than your household's gross monthly income plus your liquid resources; or your household is a migrant or seasonal farm worker household with little or no income and resources. **GIVE THE INFORMATION BELOW, SO YOUR ELIGIBILITY FOR EXPEDITED SERVICE CAN BE DETERMINED.**

Total money expected this month before deductions $_____

Total cash, money in checking/savings accounts, CDs $_____

Total rent or mortgage for this month $_____

Utility expenses for this month $_____

Which utilities do you pay? (check all that apply)

❑ Heat ❑ Lights ❑ Telephone ❑ Electricity for Air Conditioning
❑ Water ❑ Sewer ❑ Garbage ❑ Other

Is anyone in your household a migrant or seasonal farm worker? **YES ( ) NO ( )**

NAME	DATE OF BIRTH
ADDRESS	SOCIAL SECURITY NUMBER
	TELEPHONE
SIGNATURE	DATE

AGENCY USE ONLY

CASE NAME		
CASE NUMBER		
LOCALITY	**WORKER**	**DATE**

EXPEDITED SERVICE DETERMINATION

Income less than $150 and Resources $100 or less — **YES ( ) NO ( )**

Income plus resources less than shelter bills — **YES ( ) NO ( )**

For migrants or seasonal farm workers:

Resources $100 or less, and in next 10 days $25 or less is expected from new income:

OR

Resources $100 or less, and no income is expected from a terminated source for the rest of this month or next month. — **YES ( ) NO ( )**

EXPEDITE IF <u>YES</u> TO ANY OF THE ABOVE.

COMPLETE AND ACCURATE INFORMATION

You must give complete, accurate, and truthful information. If you refuse to give needed information, your eligibility for assistance may not be able to be determined. Information regarding your race is not required. However, if you decide not to give this information, your worker will complete that section. If you knowingly give false, incorrect or incomplete information, or fail to report changes, you could lose your benefits and be arrested, prosecuted, fined and/or imprisoned. If you knowingly give false, incorrect, or incomplete information in order to help someone else receive benefits, you could be arrested and prosecuted for fraud.

VIRGINIA SOCIAL SERVICES BENEFIT PROGRAMS BOOKLET

This booklet contains information about the programs available at your local social services agency plus other very important information you should know, including your responsibilities.

COMPLETING THE APPLICATION

If you need help completing this Application, a friend or relative or your eligibility worker can help you. If you are completing this application for someone else, answer each question as if you were that person. If you need to change an answer or make a correction, write the correct information nearby and put your initials and date next to the change. If more than 8 people are living in your home and you need more space to list everyone, tell the agency you need extra pages. If you want Medicaid and you are under 18 years of age, your parent or legal guardian must sign the application.

FILING THE APPLICATION

You may turn in a partially completed Application which contains at least your name, address, and signature (or the signature of your authorized representative), **but you must complete the rest of this Application before your eligibility can be determined.** For some programs, you must also be interviewed, but you may turn in your Application before your interview. You may turn in your Application any time during office hours the same day as you contact your local agency. You have the right to turn in your Application even if it looks like you may not be eligible for benefits.

YOUR FOOD STAMP RIGHTS

In accordance with Federal law and U.S. Department of Agriculture policy, the Virginia Department of Social Services is prohibited from discriminating on the basis of race, color, national origin, sex, religious creed, disability, political beliefs, or retaliation.

The Virginia Department of Social Services is an equal opportunity provider.

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

APPLICATION FOR BENEFITS

AGENCY USE ONLY				
CASE NAME	CASE NUMBER	PROGRAM	WORKER CASELOAD	DATE REC'D.
DATE OF SERVICE REFERRAL	DATE OF INTERVIEW	LOCALITY		

1. I am requesting: ( ) Food Stamps ( ) TANF ( ) Medicaid/FAMIS PLUS/FAMIS/FAMIS MOMS ( ) Plan First ( ) Other Financial or Medical Assistance
( ) I understand that an application for TANF is also an application for Food Stamps and I do not wish to apply for Food Stamps.

APPLICANT'S NAME	SOCIAL SECURITY NUMBER	PHONE NUMBER (HOME/MESSAGES) (WORK)
RESIDENCE ADDRESS (INCLUDE CITY, STATE AND ZIP CODE)		DIRECTIONS TO HOME
MAILING ADDRESS (IF DIFFERENT)		

LANGUAGE (Enter Code) _____ 1 - English 2 - Spanish 3 - Cambodian 4 - Vietnamese 5 - Farsi 6 - Haitian-Creole 7 - Laotian 8 - Chinese 9 - Korean
A - Somali B - Kurdish C – Arabic F - French G - German J - Japanese O - Other

YES ( ) NO ( ) A. Does anyone have an emergency medical need? If **YES**, give name and explain_____

YES ( ) NO ( ) B. Is the applicant living in an Assisted Living Facility, an Adult Family Care Home, a Nursing Facility, or other institution?
If **YES**, Date Applicant Entered_____ City\County and State Applicant lived before entering _____
If outside Virginia, was placement made by a government agency? **YES ( ) NO ( )**

YES ( ) NO ( ) C. ANSWER THIS QUESTION IF APPLYING FOR MEDICAID, GENERAL RELIEF OR AUXILIARY GRANTS: Does this applicant have a spouse who does not live in the home?
If **YES**, Spouse's Name _____ Spouse's Address_____

2. **YES ( ) NO ( )** Have you or anyone for whom you are applying ever applied for, or received, or are currently receiving any benefits from a social services agency, including Food Stamps, AFDC, TANF, Medicaid, General Relief, Auxiliary Grants, Foster Care, Adoption Assistance, or Refugee Cash Assistance?

APPLICANT'S NAME	SOCIAL SECURITY NUMBER	TYPE OF BENEFITS RECEIVED
WHEN	FROM WHAT COUNTY OR CITY OR STATE	

3. **YES ( ) NO ( )** Have you or anyone for whom you are applying ever been convicted of making false or misleading statements about your identity or address to receive TANF, Food Stamps, or Medicaid in two or more states at the same time? If **YES**, give date and place of conviction_____

4. **YES ( ) NO ( )** Are you or anyone for whom you are applying in violation of parole or probation or fleeing capture to avoid prosecution or punishment of a felony?
If **YES,** explain_____

5. **YES ( ) NO ( )** Do you or anyone in your home have a felony conviction for drugs after August 22, 1996 for ( ) Use? ( ) Possession? ( ) Distribution of drugs? (check all that apply) If **YES,** who?_____ Did the court assign ( ) Periodic Testing? ( ) Drug Treatment? ( ) Other Action? **YES ( ) NO ( )** If **YES,** have you finished the plan or are you cooperating? **YES ( ) NO ( )**

6. **YES ( ) NO ( )** Is there anything that you would like to talk about with a service worker? This could include concerns about your children, school problems, day care needs, family planning, referrals to other community organizations, or other problems or concerns. If **YES,** explain_____

INSTRUCTIONS

1. Do not write in the shaded areas. These areas are for agency use only.

2. Unfold this page. Use this folded page to complete **SECTION A: GENERAL INFORMATION.** Answer the questions in **SECTION A** for everyone who lives in your home, even if you are not applying for that person. You may leave questions about citizenship, immigration and Social Security Number blank for anyone for whom you are NOT requesting assistance.

3. Answer the questions in **SECTION B: RESOURCES** for everyone for whom you are applying unless you are applying for TANF, Plan First or FAMIS PLUS/ FAMIS/FAMIS MOMS. In addition, if applying for **Medicaid** also provide resource information for the following persons:

   Medicaid: Spouse and children under age 21 who live with a person for whom you are applying.
   Parents who live with a child under age 21.
   Spouse of a person in a nursing facility, state hospital, or community-based care. Provide the spouse's shelter bills to your worker.

4. Answer the questions in **SECTION C: INCOME** for everyone for whom you are applying. In addition, if applying for **TANF, Medicaid, Plan First or FAMIS PLUS/FAMIS** also provide income information for the following persons:

   TANF: Children age 18 or under, even if you are not applying for that child.
   Stepparent of the children for whom you are applying.

   Medicaid/Plan First: Spouse and children under age 21 who live with a person for whom you are applying.
   Spouse of a person in a nursing facility, state hospital, or community-based care. Provide the spouse's shelter bills to your worker.

   FAMIS PLUS/FAMIS Parents and stepparents who live with a child under age 21.

5. After completing Sections A, B, and C, answer the questions in the sections indicated below, depending on the type of assistance you are requesting.

Food Stamps	**Section D,** pages 8-9
TANF/Medicaid	**Section E,** page 10
Refugee Cash and Medical Assistance	**Section E,** page 10 **only** for children age 18 and under
FAMIS PLUS/FAMIS	**Section F,** page 11
Medicaid/Auxiliary Grants/General Relief	**Section G,** page 11
General Relief	**Section E,** page 10 **only** for children under age 18 **Sections I & J,** page 12
State and Local Hospitalization	**Section H,** page 12
Emergency Assistance	**Section J,** page 12
Auxiliary Grants	**Section K,** page 12
Plan First	**Section L,** page 12

6. Read **YOUR RESPONSIBILITIES** on page 13.

7. Read and complete **VOTER REGISTRATION** on page 13 of this application.

8. Read and complete the last page of this application. Be sure to sign and date the application.

A. GENERAL INFORMATION (ALL APPLICANTS MUST COMPLETE THIS SECTION)

	1. EVERYONE IN YOUR HOME **LIST EVERYONE LIVING IN YOUR HOME**, even if you are not applying for assistance for that person. **LIST YOURSELF ON LINE #1.** Check (√) **YES ( ) NO ( )** Do you expect any change in who lives in your home, either this month or next month? If YES, explain: _____ _____ _____ LAST NAME, FIRST, MI, AND MAIDEN (DO NOT make any entry in the ID# space)	**2. TEMPORARILY AWAY FROM HOME** Is this person temporarily away from home? Check (√) **YES** or **NO** If **YES**, give the date the person left and expected return date If more than 60 days, give the reason for the absence.	**3. RELATIONSHIP TO PERSON ON LINE #1** Give the relationship of each person to the person listed on Line #1.	**4. TYPE OF ASSISTANCE REQUESTED** (Check (√) type of assistance requested for each person. If no assistance is requested, check **NONE** for that person.										
				FOOD STAMPS	TANF	MEDICAL ASSISTANCE	PLAN FIRST	GENERAL RELIEF	EMERGENCY ASSISTANCE	AUXILIARY GRANTS	REFUGEE CASH ASSISTANCE	REFUGEE MEDICAL ASSISTANCE	NONE
1	**ID#**	**YES ( ) NO ( )** **Date Left**_____ **Expected Return Date**_____ **Reason**											
2	**ID#**	**YES ( ) NO ( )** **Date Left**_____ **Expected Return Date**_____ **Reason**											
3	**ID#**	**YES ( ) NO ( )** **Date Left**_____ **Expected Return Date**_____ **Reason**											
4	**ID#**	**YES ( ) NO ( )** **Date Left**_____ **Expected Return Date**_____ **Reason**											
5	**ID#**	**YES ( ) NO ( )** **Date Left**_____ **Expected Return Date**_____ **Reason**											
6	**ID#**	**YES ( ) NO ( )** **Date Left**_____ **Expected Return Date**_____ **Reaon**											
7	**ID#**	**YES ( ) NO ( )** **Date Left**_____ **Expected Return Date**_____ **Reason**											
8	**ID#**	**YES ( ) NO ( )** **Date Left**_____ **Expected Return Date**_____ **Reason**											

Determine reason person is away.
Determine if any parents or spouses live in the home.
Determine if persons under 18 are under parental control.
Determine if anyone is a payee for anyone else.

Determine living arrangement, such as subsidized housing for elderly, hospital, incarceration, etc.
If person is in ALF nursing facility, state hospital, or CBC, determine if a spouse, dependent, child, or dependent relative is in the home.
Determine living arrangement of the minor parent.

USE THE FOLDOUT TO COMPLETE THIS SECTION

5. U.S. CITIZEN* Check (√) **YES** or **NO** If YES, do not answer Question 6. You may leave this blank for anyone not in the assistance request	6. ANSWER ONLY IF AN ALIEN Give the **Alien Number** and **Date of Entry** for anyone for whom you are requesting assistance. You may leave this blank for anyone not in the assistance request.	7. PLACE OF BIRTH Give the **State** if born in the U.S. or the **Country** if born outside of the U.S. 8. DATE OF BIRTH	9a. RACE (not required) Select all that apply 1. White 2. Black/African American 3. American Indian/Alaska Native 4. Asian 5. Native Hawaiian/ Pacific Islander	9b. ETHNICITY (not required) Give the **code** to show ethnicity. 1 - Hispanic or Latino 2 - Not Hispanic or Latino	10. SEX Give the **code** to show Sex. M - Male F - Female	11. SOCIAL SECURITY NUMBER Give the number for anyone for whom you are requesting assistance.	12. MARITAL STATUS Give the **code** to show Marital status. 1 - Married 2 - Never Married 3 - Divorced 4 - Widowed 5 - Separated	13. VETERAN/ DEPENDENT OF A VETERAN Check (√) **YES or NO**
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )
YES ( ) NO ( )	Alien Number Date of Entry	Place of Birth Date of Birth						YES ( ) NO ( )

***U.S. Citizens: You must prove you are a U.S. citizen for Medicaid purposes unless you receive SSI, SSDI, or you are a Medicare beneficiary. You must show documents such as a birth certificate to show that you are a citizen and you must prove your identity (often something with your picture on it) in order to receive Medicaid benefits. If you cannot provide documentation, let the worker know right away. Your Medicaid benefits could be canceled or denied if you do not tell us that you are trying to get these documents or that you need help. For children under age 16, a parent's or an authorized representative's signature on this application will serve as proof of identity, but you must still provide proof of citizenship for children under age 16.**

For Aliens, photocopy INS document. Inquire if requesting emergency care. Determine if sponsored. Obtain sponsor's name address, income, and resources. For Asylees, verify date asylum was granted. For Veterans, make referral to V.A.

USE THE FOLDOUT TO COMPLETE THIS SECTION

14. MEDICAL EXPENSES DURING THE 3 MONTHS BEFORE THIS MONTH. Check (√) **YES or NO** If **YES**, give the **Date of the Expense**.	**15. EDUCATION** Give the **Last Grade Completed** in school. Check (√) **YES or NO** Is the person a High School (HS) or GED graduate? Check (√) **YES or NO** Is the person **Currently Enrolled** in school? If **YES**, give the **school name** and use one of the **codes** to show enrollment. FT - Enrolled full time HT - Enrolled half time LT - Enrolled less than half time	SCHOOL NAME	ENROLLMENT CODE	**16. DISABILITY/ PREGNANT STATUS** Give the **code** to show Disability/Pregnant Status ND - Not disabled DS - Disabled BL - Blind CD - Needed to care for disabld person PG - Pregnant	**17. ANSWER ONLY IF DISABLED** A. Check (√) if the disability reduces or prevents the ability to work or to obtain work. B. Check (√) if the disability reduces or prevents the ability to care for a child in the home. C. Check (√) if the disability requires someone to be in the home to provide care.	18. **ANSWER ONLY IF PREGNANT AND APPLYING FOR MEDICAID AND FAMIS MOMS** Give the **Conception** month and year and the **Expected Delivery Date**, and the number of **Unborn Children**.
YES ( ) NO ( ) Date	**A. Last Grade Completed:** ___________ **B. ( ) YES ( ) NO HS or GED Graduate** **C. ( ) YES ( ) NO Currently Enrolled**				**A. ( ) Ability to work is reduced** **B. ( ) Ability to care for child is reduced** **C. ( ) Someone is needed in the home**	**Conception** **Delivery** **# Unborn**
YES ( ) NO ( ) Date	**A. Last Grade Completed:** ___________ **B. ( ) YES ( ) NO HS or GED Graduate** **C. ( ) YES ( ) NO Currently Enrolled**				**A. ( ) Ability to work is reduced** **B. ( ) Ability to care for child is reduced** **C. ( ) Someone is needed in the home**	**Conception** **Delivery** **# Unborn**
YES ( ) NO ( ) Date	**A. Last Grade Completed:** ___________ **B. ( ) YES ( ) NO HS or GED Graduate** **C. ( ) YES ( ) NO Currently Enrolled**				**A. ( ) Ability to work is reduced** **B. ( ) Ability to care for child is reduced** **C. ( ) Someone is needed in the home**	**Conception** **Delivery** **# Unborn**
YES ( ) NO ( ) Date	**A. Last Grade Completed:** ___________ **B. ( ) YES ( ) NO HS or GED Graduate** **C. ( ) YES ( ) NO Currently Enrolled**				**A. ( ) Ability to work is reduced** **B. ( ) Ability to care for child is reduced** **C. ( ) Someone is needed in the home**	**Conception** **Delivery** **# Unborn**
YES ( ) NO ( ) Date	**A. Last Grade Completed:** ___________ **B. ( ) YES ( ) NO HS or GED Graduate** **C. ( ) YES ( ) NO Currently Enrolled**				**A. ( ) Ability to work is reduced** **B. ( ) Ability to care for child is reduced** **C. ( ) Someone is needed in the home**	**Conception** **Delivery** **# Unborn**
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YES ( ) NO ( ) Date	**A. Last Grade Completed:** ___________ **B. ( ) YES ( ) NO HS or GED Graduate** **C. ( ) YES ( ) NO Currently Enrolled**				**A. ( ) Ability to work is reduced** **B. ( ) Ability to care for child is reduced** **C. ( ) Someone is needed in the home**	**Conception** **Delivery** **# Unborn**
YES ( ) NO ( ) Date	**A. Last Grade Completed:** ___________ **B. ( ) YES ( ) NO HS or GED Graduate** **C. ( ) YES ( ) NO Currently Enrolled**				**A. ( ) Ability to work is reduced** **B. ( ) Ability to care for child is reduced** **C. ( ) Someone is needed in the home**	**Conception** **Delivery** **# Unborn**

For Medical Expenses, determine retroactive Medicaid entitlement.

B. RESOURCES

Do not complete this section if you are applying only for TANF, FAMIS PLUS, FAMIS, FAMIS MOMS, or Medicaid for parents of dependent children. If you are applying for Plan First, answer Question #9 only in this section. For all other programs, answer the resource questions for everyone for whom you are applying. If applying for Medicaid for aged, blind, or disabled adults or medically needy children, also provide resource information for the spouse or parents. See Page 1a. Include any resources anyone owns, is currently buying, or is heir to. Include any resources jointly owned with someone else, even if that person does not live with you. List the names of all joint owners. After each joint owner's name, list the percentage (%) of the resource owned by that person. TALK TO YOUR ELIGIBILITY WORKER IF YOU NEED HELP ANSWERING THESE QUESTIONS, INCLUDING THE PERCENTAGE OWNED.

YES ( ) NO ( ) 1. Cash on hand and not in a bank? If **YES**, list owner(s)_____ Amount_____

YES ( ) NO ( ) 2. Checking account, savings or investment account, credit union account, Christmas Club account, CDs or money market account, individual development account, patient funds for people in a nursing facility or Assisted Living Facility, or special welfare fund account? List all accounts, even if there is no money in the account. If **Yes** to savings or investment account, has the savings account been set up to pay for school expenses, to make a down payment on a house, or to start a business? Check (√) **YES ( ) NO ( )** If the savings account is to pay for school expenses, list the person(s) whose expenses will be paid _____. If the savings or investment account is for another purpose, explain _____

OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	YES ( ) NO ( ) Is this resource used in your business or trade, including farming?	AMOUNT $	DATE ACQUIRED
OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	YES ( ) NO ( ) Is this resource used in your business or trade, including farming?	AMOUNT $	DATE ACQUIRED
OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	YES ( ) NO ( ) Is this resource used in your business or trade, including farming?	AMOUNT $	DATE ACQUIRED

YES ( ) NO ( ) 3. Stocks or bonds, trust funds, pension plans, retirement accounts, promissory notes, deeds of trust, mutual funds, IRAs, or annuities?

OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	AMOUNT $	DATE ACQUIRED
OWNER(S)	TYPE OF ACCOUNT ACCOUNT #	WHERE	AMOUNT $	DATE ACQUIRED

YES ( ) NO ( ) 4. Has anyone sold, transferred, or given away any resources in the last 3 months if applying for Food Stamps?
In the last 2 years, if applying for **General Relief**? Any resources or income in the last 5 years if applying for **Medicaid**?

PROPERTY TRANSFERRED		VALUE AT TRANSFER $	AMOUNT RECEIVED $	EXPLAIN REASON FOR TRANSFER
FROM WHOM	TO WHOM	DATE ACQUIRED	DATE TRANSFERRED	

Answer the questions below this point (5-12B) <u>only</u> if this is an application for Medicaid, General Relief, Emergency Assistance, State and Local Hospitalization, Auxiliary Grants, or Refugee Medical Assistance.

YES ( ) NO ( ) 5. Burial plots, burial arrangement or trust funds for burial?

OWNER(S)	NUMBER OF PLOTS, TYPE OF ARRANGEMENT	WHERE	VALUE $ AMOUNT OWED $	DATE ACQUIRED
OWNER(S)	NUMBER OF PLOTS, TYPE OF ARRANGEMENT	WHERE	VALUE $ AMOUNT OWED $	DATE ACQUIRED

YES ( ) NO ( ) 6. Personal property, such as campers/trailers, non-motorized boats, utility trailers, tools, equipment, supplies, or livestock?

OWNER(S)	TYPE	YES ( ) NO ( ) Is this property necessary to your business or trade, including farming?	VALUE $ AMOUNT OWED $	DATE ACQUIRED

YES ( ) NO ( ) 7. Real property, including life estates, land, buildings, or mobile homes? If **YES**, do you live there? Check (√) **YES ( ) NO ( )**

OWNER(S)	TYPE (INCLUDE NUMBER OF ACRES)	YES ( ) NO ( ) Currently rented YES ( ) NO ( ) Income producing YES ( ) NO ( ) Currently for sale	VALUE $ AMOUNT OWED $	DATE ACQUIRED

YES ( ) NO ( ) 8. Licensed or unlicensed vehicles, such as cars, trucks, vans, motorboats, motor homes, mobile homes, recreational vehicles, or motorcycles/mopeds?

OWNERS	TYPE OF VEHICLE: YEAR-MAKE-MODEL VEHICLE ID#	CURRENTLY LICENSED? YES ( ) NO ( )	LICENSE #	VALUE $ AMOUNT OWED $	EXPLAIN HOW VEHICLE IS USED	DATE ACQUIRED
OWNERS	TYPE OF VEHICLE: YEAR-MAKE-MODEL VEHICLE ID#	CURRENTLY LICENSED? YES ( ) NO ( )	LICENSE #	VALUE $ AMOUNT OWED $	EXPLAIN HOW VEHICLE IS USED	DATE ACQUIRED

YES ( ) NO ( ) 9. Health insurance or long term care insurance?

POLICY HOLDER	COMPANY NAME, ADDRESS, PHONE	BEGIN DATE END DATE	ID NUMBER PREMIUM AMOUNT $	TYPE OF COVERAGE	PERSON(S) INSURED
POLICY HOLDER	COMPANY NAME, ADDRESS, PHONE	BEGIN DATE END DATE	ID NUMBER PREMIUM AMOUNT $	TYPE OF COVERAGE	PERSON(S) INSURED

YES ( ) NO ( ) 10. Medicare?

PERSON INSURED	CLAIM NUMBER	CHECK (√) ( ) PART A ( ) PART B	BEGIN DATE END DATE	PREMIUM	PAYMENT METHOD
PERSON INSURED	CLAIM NUMBER	CHECK (√) ( ) PART A ( ) PART B	BEGIN DATE END DATE	PREMIUM	PAYMENT METHOD

YES ( ) NO ( ) 11. Life insurance policies?

OWNER(S)	PERSON(S) INSURED	COMPANY NAME, ADDRESS, PHONE	TYPE OF POLICY	POLICY NUMBER	FACE VALUE $	CASH VALUE $	DATE ACQUIRED
OWNER(S)	PERSON(S) INSURED	COMPANY NAME, ADDRESS, PHONE	TYPE OF POLICY	POLICY NUMBER	FACE VALUE $	CASH VALUE $	DATE ACQUIRED

YES ( ) NO ( ) 12A. Does anyone expect to receive any money because of a legal suit involving personal injury or property damage? If **YES**, explain.
YES ( ) NO ( ) 12B. Does anyone expect a change in resources this month or next month? If **YES**, explain and give date change is expected.

EXPLAIN

C. INCOME (ALL APPLICANTS MUST COMPLETE THIS SECTION)

Answer the income questions for everyone for whom you are applying. If applying for **TANF, Medicaid, Plan First** or **SLH**, also provide income information for the additional persons indicated on the INSTRUCTIONS page. And for **TANF** and **Medicaid/FAMIS PLUS/FAMIS** for children, also provide income information for the child's parent or stepparent living in the home; or any person living with the parent as husband or wife. If the parent is a minor under age 18 (for **TANF**) or under age 21 (for **Medicaid**), also provide income information for the parent of the minor parent.

1. Does anyone receive any of the following types of money from working? Check (√) **YES or NO** for each type. If **YES**, give the information requested.

YES ( ) NO ( ) Wages/salary
YES ( ) NO ( ) Contract income
YES ( ) NO ( ) Commissions, bonuses, tips
YES ( ) NO ( ) Vacation Pay
YES ( ) NO ( ) Earned sick pay
YES ( ) NO ( ) Babysitting/day care
YES ( ) NO ( ) Farming/fishing
YES ( ) NO ( ) Domestic work
YES ( ) NO ( ) Odd jobs
YES ( ) NO ( ) Other self- employment
YES ( ) NO ( ) Any other money from working

PERSON RECEIVING MONEY FROM WORKING	EMPLOYER'S NAME, ADDRESS PHONE NUMBER	EMPLOYMENT BEGIN DATE	HOURS WORKED PER MONTH	RATE OF PAY	HOW OFTEN PAID	DAY OF THE WEEK PAID	GROSS MONTHLY PAY BEFORE DEDUCTIONS
				$ PER			$
				$ PER			$
				$ PER			$

2. Does anyone receive any other type of money? Check (√) **YES OR NO** for each type. If **YES**, give the information requested.

YES ( ) NO ( ) Social Security
YES ( ) NO ( ) SSI
YES ( ) NO ( ) VA benefits
YES ( ) NO ( ) Black Lung benefits
YES ( ) NO ( ) Railroad retirement
YES ( ) NO ( ) Other retirement
YES ( ) NO ( ) Child support, alimony
YES ( ) NO ( ) Military Allotment
YES ( ) NO ( ) Unemployment benefits
YES ( ) NO ( ) Worker compensation
YES ( ) NO ( ) Strike benefits
YES ( ) NO ( ) Interest, dividends
YES ( ) NO ( ) Cash gifts or contributions
YES ( ) NO ( ) Public Assistance
YES ( ) NO ( ) Room/board income
YES ( ) NO ( ) Rental Income
YES ( ) NO ( ) Prize winnings
YES ( ) NO ( ) Insurance settlement
YES ( ) NO ( ) Loans
YES ( ) NO ( ) Training allowances, including WIA
YES ( ) NO ( ) Inheritance
YES ( ) NO ( ) All food, clothing, utilities, or rent
YES ( ) NO ( ) Any other type of money

PERSON RECEIVING MONEY	TYPE OF MONEY RECEIVED	HOW OFTEN RECEIVED	WHEN RECEIVED	GROSS MONTHLY AMOUNT BEFORE DEDUCTIONS
				$
				$
				$
				$

For Self Employment Income, determine expenses.
For Day Care Income, determine whether child lives in the home, number of snacks or meals, expenses.
For Roomer/Boarder Income, determine whether heat is provided, number of meals provided per day.
For Rental Income, determine whether property is actively self-managed, expenses.
For Earned Income, determine whether earnings include EITC advance payments.
Inquire if SSI has been applied for.
For Food Stamps, investigate voluntary quit/work reduction.
For TANF, determine the day care option.
For Medicaid, determine income of spouse, dependent child, or dependent relative of person in nursing facility, state hospital, or CBC.

YES ( ) NO ( ) 3. Has anyone been fired, laid off, gone on sick or maternity leave, gone on strike, quit a job or reduced hours worked in the last 60 days?

NAME OF PERSON	EMPLOYER'S NAME, ADDRESS PHONE	EMPLOYED FROM/TO	HRS./WK. WORKED	RATE OF PAY	HOW OFTEN PAID	DATE LAST PAY RECEIVED	REASON FOR LEAVING, REDUCING HOURS
				$ PER			

YES ( ) NO ( ) 4. Does anyone besides the people for whom you are applying pay directly for you, help you pay, or lend you money to pay rent, utilities, medical bills or any other bills? Or, does anyone totally supply food or clothing for you or someone else on a regular basis?

PERSON RECEIVING HELP	PERSON PROVIDING HELP	TYPE OF HELP RECEIVED	AMOUNT	DOES MONEY COME DIRECTLY TO YOU?	IS THIS A LOAN?	IS REPAYMENT EXPECTED
			$ PER	YES ( ) NO ( )	YES ( ) NO ( )	YES ( ) NO ( )
			$ PER	YES ( ) NO ( )	YES ( ) NO ( )	YES ( ) NO ( )

YES ( ) NO ( ) 5. Has anyone applied for or received student financial aid or work-study for a current school term at a college or university? Or, any school or training program beyond the high school level? Or, any school or training program for the physically or mentally disabled?

				SCHOOL EXPENSES					
NAME OF PERSON	TYPE OF FINANCIAL AID	AMOUNT	PERIOD COVERED	TUITION FEES	BOOKS/ SUPPLIES	TRANSPOR-TATION	DEPENDENT CARE	ROOM & BOARD	OTHER (specify)
		$	FROM TO	$	$	$	$	$	$
		$	FROM TO	$	$	$	$	$	$

YES ( ) NO ( ) 6. Does anyone expect any change in the type of money received, employment, or hours worked, either this month or next month?

If **YES**, explain and give date: _____

YES ( ) NO ( ) 7. Does anyone have a day care expense for a child, an elderly person, or an adult with a disability?

PERSON PAYING FOR CARE	PERSON RECEIVING CARE	CHECK (√) IF DISABLED	PROVIDER'S NAME, ADDRESS, PHONE NUMBER	AMOUNT PAID
		( ) Disabled		$ PER
		( ) Disabled		$ PER

YES ( ) NO ( ) 8. Does anyone pay legally obligated child support to someone not in the household? If **YES,** person paying: _____

Person supported: _____ Amount paid and how often: _____

YES ( ) NO ( ) 9. **ANSWER ONLY IF SOMEONE IS APPLYING FOR MEDICAID AND IS BLIND OR DISABLED:** Does this person have a work related expense?

If **YES,** give amount and explain: _____

D. FOOD STAMPS

1. List the name of the person who is the head of your household: _____.

NOTE: Refer to the Benefit Programs Booklet for information about naming the Head of Household.

YES ( ) NO ( ) 2. Would you like to name an authorized representative who could apply for food stamps for you, access your food stamp account to buy food for you, or receive food stamp correspondence and notices for you? You may have only one representative who can access your benefits.

	NAME, ADDRESS, PHONE NUMBER OF AUTHORIZED REPRESENTATIVE(S)	CHECK (√) EACH DUTY AUTHORIZED FOR THAT PERSON
1		( ) Apply for food stamps ( ) Receive correspondence ( ) Receive food stamps
2		( ) Apply for food stamps ( ) Receive correspondence ( ) Receive food stamps

An authorized representative must have written permission to apply for food stamps. This permission may be given in the space above or in a letter. Only the head of the household, the spouse, or any adult member of the household age 18 or older may give permission for a representative.

YES ( ) NO ( ) 3. Is anyone living in your home NOT included on your Food Stamp application?

If **YES**, do you and everyone for whom you are applying usually purchase and prepare meals apart from these people? Or, do you intend to do so if your application for Food Stamps is approved? Check (√) **YES ( ) NO ( ) IF YES**, list names: _____

YES ( ) NO ( ) 4. Is anyone living in your home a roomer or a boarder? If **YES**, list names: _____

YES ( ) NO ( ) 5. Is anyone age 60 or older, **OR** approved to receive Medicaid because of a disability, **OR** receiving any type of disability check?

If **YES**, list all current medical expenses for these people, including Medicare premiums, other medical insurance premiums, medical and dental bills, psychotherapy, prescription drugs, eye glasses, dentures, hearing aids, transportation for medical services, nursing services, and any other medical bills. ALSO, indicate how you would like these medical expenses deducted in order to determine your food stamp benefits. TALK TO YOUR WORKER BEFORE ANSWERING METHOD OF DEDUCTION.

PERSON WITH EXPENSE	TYPE OF EXPENSE	AMOUNT	NAME, ADDRESS, PHONE NUMBER OF DOCTOR, HOSPITAL, PHARMACY	METHOD OF DEDUCTION
		$		( ) Lump sum ( ) Monthly average ( ) Expected payment
		$		( ) Lump sum ( ) Monthly average ( ) Expected payment
		$		( ) Lump sum ( ) Monthly average ( ) Expected payment

YES ( ) NO ( ) 6. Does anyone have shelter expenses for rent or mortgage, real estate tax, property tax on a mobile home, home owner's insurance, electricity, gas, kerosene, coal, oil, wood, water or sewer, telephone, or initial installation fee for utilities or telephone? If **YES,** answer question a, b, and c. Then, give the information requested in boxes.

a. **YES ( ) NO ( )** Are any utilities included in your rent? If **Yes**, leave the boxes for those expenses blank.

b. **YES ( ) NO ( )** Are taxes or insurance included in your mortgage payment? If **Yes,** leave those boxes blank.

c. **YES ( ) NO ( )** Do you have an expense for telephone services? If **Yes**, does anyone living in your home but not included on your Food Stamp application help you pay your telephone bill? Check (√) **YES ( )** or **NO ( )**

If **YES**, explain: _____

EXPENSE	Rent or Mortgage	Taxes	Insurance	Electricity	Gas	Kerosene	Coal	Oil	Wood	Water/Sewer	Garbage	Installation
AMOUNT BILLED	$	$	$	$	$	$	$	$	$	$	$	$
HOW OFTEN												
WHO PAYS BILL												

YES ( ) NO ( ) 7. Does anyone have or expect to have an expense for heating or cooling the home? Or, has anyone received assistance from the Fuel Assistance Program during this past year?

If **YES**, check (√) whether you would like your food stamp benefits determined using your actual utility expenses or a standard amount we use for these expenses. TALK TO YOUR WORKER BEFORE ANSWERING. **Actual Utility Expenses ( ) Utility Standard ( )**

If the **Utility Standard** is selected, does anyone living in your home but not included on your Food Stamp application help you pay your heating or cooling bill? Check (√) **YES ( ) NO ( )** If **YES,** explain: _____

YES ( ) NO ( ) 8. Are you staying temporarily in someone else's home, an emergency shelter, welfare hotel, other halfway house, or a place not usually used for sleeping? If temporarily staying in someone else's home, give the date you moved in: _____

If **YES,** check (√) whether you would like your food stamp benefits determined using your actual shelter expenses or a standard amount we use for these expenses. TALK TO YOUR WORKER BEFORE ANSWERING. **Actual Shelter Expenses ( ) Homeless Shelter Allowance ( )**

YES ( ) NO ( ) 9. Does anyone have a shelter expense for a home (rented or owned) that is temporarily not lived in because of employment or training away from home, illness, or a disaster?

REASON FOR NOT LIVING THERE	DOES PERSON INTEND TO RETURN?	TYPE AND AMOUNT OF SHELTER EXPENSES	IS SOMEONE ELSE LIVING THERE?	IF SOMEONE ELSE LIVES THERE, DOES THAT PERSON PAY RENT?
	YES ( ) NO ( )		YES ( ) NO ( )	YES ( ) NO ( )

E. FINANCIAL AND MEDICAL ASSISTANCE FOR FAMILIES WITH CHILDREN

(ASK FOR AN EXTRA PAGE IF YOU NEED MORE SPACE)

1. CHILD/PARENT INFORMATION List each child for whom you are applying. Then, list the names of both parents. YOU MUST IDENTIFY BOTH PARENTS IN ORDER TO RECEIVE TANF. IF YOU INTENTIONALLY MISIDENTIFY A PARENT, YOU SHALL BE PROSECUTED	**2. PARENT'S STATUS** (Not needed for Medicaid) Check if either PARENT is:				**3. IMMUNIZATION** (Not needed for Medicaid) (Answer **only if applying for TANF and the child is not in school.)** Has the child received **ALL** of the immunizations required according to the child's age? Check (√) **YES** or **NO** or **UNKNOWN**
	UNEMPLOYED	DISABLED	DEAD	ABSENT	
CHILD'S NAME					YES ( ) NO ( ) UNKNOWN ( )
MOTHER					
FATHER					
CHILD'S NAME					YES ( ) NO ( ) UNKNOWN ( )
MOTHER					
FATHER					
CHILD'S NAME					YES ( ) NO ( ) UNKNOWN ( )
MOTHER					
FATHER					
CHILD'S NAME					YES ( ) NO ( ) UNKNOWN ( )
MOTHER					
FATHER					

F. FAMIS PLUS/FAMIS

YES ( ) NO ( ) 1. Did any of the children listed above have health insurance in the past 4 months? If **YES**, (a) list name of child, type of insurance, such as doctor, hospital, drugs, dental, vision, etc., and the date the insurance ended; and (b) select the reason the insurance ended.

Child: _____ Type of insurance: _____

Date ended _____

Reason insurance ended:

( ) The parent or stepparent changed jobs or stopped employment and no other employer contributes to the cost of family coverage.
( ) The parent or stepparent's employer stopped contributing to the cost of family coverage and no other employer contributes to the cost of family coverage.
( ) Child uninsurable—insurance company discontinued coverage. (Provide proof that coverage stopped by insurance company)
( ) Cost exceeded 10% of monthly income (before taxes). (Provide proof of cost of monthly premium)
( ) Stopped/dropped by someone other than parent or stepparent.
( ) Stopped/dropped Cobra policy
( ) Other _____

YES ( ) NO ( ) 2. Is any member of the family, including a stepparent who lives in the home, employed by a state or local government agency? If **YES**, list name of family member(s) and agency name: _____

YES ( ) NO ( ) 3. Does the employer of any member of the family offer health insurance for family members? If **YES**, list the names of the children listed on this application who can get insurance through the employer? _____

G. AGED, BLIND OR DISABLED INDIVIDUALS

YES ( ) NO ( ) 1. Have you ever applied for Supplemental Security Income (SSI) or Social Security as a disabled person? If **YES,** date applied: _____
Check one: ( ) No Decision Yet ( ) Application Approved ( ) Application Denied

YES ( ) NO ( ) 2. If your application was denied, did you file an appeal of the denial? If **YES**, explain the action taken by the Social Security Administration (SSA) on the appeal request? _____

YES ( ) NO ( ) 3. Has it been less than 12 months since your most recent application for Social Security or SSI disability benefits was denied? If **YES**, list the medical conditions that you asked SSA to evaluate. _____.

YES ( ) NO ( ) 4. Has your condition changed or worsened since your most recent application for Social Security or SSI disability benefits was denied. If **YES**, explain how your condition has changed or worsened. _____

YES ( ) NO ( ) 5. Do you have a new condition that has occurred since your most recent application for Social Security or SSI disability benefits was denied? If **YES**, explain the new condition. _____

YES ( ) NO ( ) 6. Did you receive an Auxiliary Grants check that has stopped? If **YES**, explain when and why the payments stopped. _____
_____

YES ( ) NO ( ) 7. Did you receive a SSI check that has stopped? If **YES**, explain when and why the payments stopped. _____
_____

H. STATE AND LOCAL HOSPITALIZATION

YES ( ) NO ( ) Have you received or will you be receiving in-patient/out-patient hospitalization services, or ambulatory surgical services, or services through a health department clinic? If **YES**, please fill out the following:

PERSON RECEIVING SERVICES	NAME OF HOSPITAL OR CLINIC	IF SERVICE HAS ALREADY BEEN RECEIVED, GIVE THE DATES BELOW DATE ADMITTED: DATE DISCHARGED:

If you were hospitalized as the result of an accident, complete the following:

WHAT HAPPENED, WHERE, HOW	NAME, ADDRESS OR PERSON AT FAULT	IS A LIABILITY SUIT PLANNED OR IN PROGRESS? YES ( ) NO ( )

NAME, ADDRESS OF ALL INSURANCE COMPANIES INVOLVED	NAME, ADDRESS, PHONE NUMBER OF YOUR ATTORNEY

I. GENERAL RELIEF

YES ( ) NO ( ) Does anyone have any responsibility for rent or utility bills (not telephone), even if someone else helps pay?

J. GENERAL RELIEF/EMERGENCY ASSISTANCE

YES ( ) NO ( ) Does anyone have any emergency food, rent, utility (not deposits), medical, clothing, transient or relocation expenses?

DESCRIPTION AND CAUSE OF EMERGENCY

K. AUXILIARY GRANTS

YES ( ) NO ( ) 1. Do you own any household goods or personal effects which are worth more than $500, such as silver, fine china, furs, artwork, expensive jewelry, or other expensive items?

DESCRIPTION AND VALUE OF ITEMS

YES ( ) NO ( ) 2. Do you owe or did you pay in the month of application any bills you had before you entered the assisted living facility or adult family care?

DESCRIPTION OF BILLS	DATES OF BILLS	DATES BILLS PAID

L. PLAN FIRST

YES ( ) NO ( ) Has the person(s) applying for Plan First coverage had a procedure that now prevents pregnancies (tubes tied, hysterectomy)? For men, this includes a vasectomy. If yes, please list the person's name: _____.

YOUR RESPONSIBILITIES (READ THIS SECTION CAREFULLY BEFORE SIGNING THIS APPLICATION)

CHANGES

You must report the following changes for the Medicaid Program within 10 days. You must report these changes for the Auxiliary Grants and General Relief Programs the day the change occurs or the first day that the agency is open after the change occurs.

1) Change of address and any changes in shelter costs due to the move
2) Change in the persons in the household – person left, person born, etc.
3) Change in source of income, getting a new job, stopping a job, other benefits, etc.
4) Change in work hours from part-time to full-time or full-time to part-time
5) Change in rate of pay per hour/day, etc.
6) Change in the amount of monthly income received other than from a job, including the loss of SSI benefits
7) Change in resources, including transferring assets/property
8) Change in motor vehicles owned
9) Change in marital status
10) Person in home is no longer disabled
11) Change in dependent care expenses
12) Change in insurance
13) Termination of a pregnancy
14) Other changes that may affect eligibility

You must report the following changes for the Food Stamp and Temporary Assistance for Needy Families (TANF) Programs within 10 days, but no later than the 10th day of the month after the change occurs.

1) Change in household income that exceeds 130% of the Federal poverty level. See the Change Report for amounts.
2) Change in address.
3) An eligible child has left the home.
4) Changes needed for VIEW (TANF work program).
5) Change in work hours for some food stamp recipients.

PENALTIES FOR FOOD STAMP VIOLATIONS

You must not give false information or hide information to get food stamps. You must not trade or sell EBT cards. You must not use food stamp benefits to buy non-food items, such as alcohol, tobacco or paper products. You must not use someone else's, EBT card for your household.

If you intentionally break any of these rules you could be barred from the Food Stamp Program for 12 months (1st violation), 24 months (2nd violation), or permanently (3rd violation); subject to $250,000 fine, imprisoned up to 20 years, or both; and suspended for an additional 18 months and further prosecuted under other Federal and State laws.

If you intentionally give false information or hide information about identity or residence to get food stamps in more than one locality at the same time, you could be barred for 10 years.

If you are convicted in court of trading or selling food stamps of $500.00 or more, you could be barred permanently.

If you are convicted in court of trading food stamps for a controlled substance, you could be barred for 24 months for the 1st violation, permanently for the 2nd violation.

If you are convicted in court of trading food stamps for firearms, ammunition, or explosives, you could be barred permanently for the first violation.

INFORMATION ABOUT THE DIVISION OF CHILD SUPPORT ENFORCEMENT (DCSE)

In order to receive TANF, you are required to assign all of your rights to financial support paid to you and to everyone else for whom you are receiving TANF. You must give to DCSE any support payments you receive after you receive your first TANF check. By accepting the TANF check, you are agreeing to assign these rights.

PENALTIES FOR TANF VIOLATIONS

You must not knowingly give false information, hide information, or fail to report changes on time in order to receive TANF or to receive supportive or transitional services such as child care or assistance with transportation.

If you are found guilty of intentionally breaking these rules, you will be ineligible to receive TANF for yourself for 6 months (1st violation), 12 months (2nd violation), or permanently (3rd violation). In addition, you may be prosecuted under Federal or State law.

Anyone convicted of misrepresenting his or her residence to get TANF, Medicaid, Food Stamps or SSI in two or more states is ineligible for TANF for 10 years.

Anyone convicted of a drug-related felony for actions that occurred after August 22, 1996, could be barred permanently.

PENALTIES FOR MEDICAID FRAUD/ABUSE

You must not deliberately withhold or hide information or givie false information to get Medicaid, FAMIS Plus or Plan First benefits. Medicaid fraud also occurs when a provider bills for services that were not delivered to a Medicaid recipient, or when a recipient shares the Medicaid number with another person to get medical services.

If you are convicted of Medicaid fraud in a criminal court, you must repay the program for all losses (paid claims or managed care premiums) and cannot get Medicaid for one year after conviction. In addition, the sentence could include a fine up to $25,000 and up to 20 years in prison. You may also have to repay any claims and managed care premiums paid when you were not eligible for Medicaid due to acts that are not considered criminal. Fraud and abuse should be reported to your local social services office or to the Department of Medical Assistance Services Recipient Audit Unit at (804) 785-0156.

VOTER REGISTRATION

If you are applying for TANF, Food Stamps, Medicaid or Plan First, check one of the following:

If you are not registered to vote where you live now, would you like to register to vote here today?

☐ Yes, I would like to register to vote. (If you would like help filling out the voter registration application form, we will help you. The decision to accept help is yours. You also have the right to fill out your voter registration application form in private.)

☐ I do not want to apply to register to vote today.

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applying to register or declining to register to vote will not affect the amount assistance or services that you will be provided by this agency. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: Secretary of the Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497, (804) 864-8901.

Agency Use Only: Face-to-face interview not required. A voter registration form was mailed. Date form mailed_____

BY MY SIGNATURE BELOW, I DECLARE:

- I understand all the information in the GENERAL INFORMATION and the YOUR RESPONSIBILITIES sections of this application.
- I understand that if I refuse to cooperate with any review of my eligibility including review by Quality Control, my benefits may be denied until I cooperate.
- I understand that if my application is for Food Stamps, failure to report or verify any of my expenses will be seen as a statement by my household that I do not want to receive a deduction for these expenses.
- I understand that Medicaid, FAMIS, and DMAS contractors may exchange information relating to my child(ren)'s coverage with local educational agencies to assist with application, enrollment, administration, and billing for services provided to my child in school. I understand that I can revoke the consent to disclose information at any time.
- I understand that to receive benefits from the Medicaid/FAMIS PLUS/Plan First/FAMIS programs, I must agree to assign my rights and the rights of anyone for whom I am applying to medical support and other third-party payments to the Department of Medical Assistance Services. If I do not agree to assign my rights, I will be ineligible for Medicaid.
- I understand that all money I receive for diagnosis or treatment of any injury, disease, disability, or medical care support must be sent to the Third-Party Liability Section, Department of Medical Assistance Services, Suite 1300, 600 East Broad Street, Richmond, VA 23219.
- I understand that I have the right to file a complaint if I believe I have been discriminated against because of race, color, national origin, sex, age, disability, or religious or political beliefs.
- I understand that I must report ownership of all annuities my spouse or I have. I also understand that my spouse and I may have to name the Commonwealth of Virginia as the beneficiary on any annuities we may have in order for Medicaid to pay long-term care costs.
- If I am applying for Medicaid, I understand that I must cooperate in establishing paternity and obtaining medical support for my children. I understand that failure to cooperate may cause my ineligibility for Medicaid.
- I understand that I have the right to appeal and have a fair hearing if I am: (1) not notified in writing of the decision regarding my application within specified time frames (10 days); (2) denied benefits from the programs for which I applied; or (3) dissatisfied with any other decision that affects my receipt of Medicaid/FAMIS PLUS/Plan First. For FAMIS/ FAMIS MOMS, there will be no opportunity for review of a negative action if the sole basis for the action is exhaustion of funding.
- I will report any changes in my situation within the time frames specified on page 13 to my local department of social services.
- I have given true and correct information on this application to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report a change promptly or on purpose, I may be breaking the law and could be prosecuted for perjury, larceny, and/or welfare fraud. I understand that if I help someone complete this form so as to get benefits he or she is not entitled to receive, I may be breaking the law and could be prosecuted.
- I understand that my signature on this application certifies, under penalty of perjury, that I am a U.S. Citizen or alien in lawful immigration status (unless applying for emergency services only). I understand the information provided on this application can be used to establish identity for children under age 16 for medical assistance purposes.
- I authorize the Department of Social Services and the Department of Medical Assistance Services to obtain any verification necessary to both determine and review financial or medical assistance eligibility. This authorization includes the release of any medical or psychological information obtained from any source to any state or local agency that may review this application and the release to the Department of Medical Assistance Services of any information in any medical records pertaining to any services received by me or anyone for whom I applied. This authorization is valid for one year from the date of my signature below. I understand that this time limit does not apply as long as my medical assistance case is open or to investigations regarding possible fraud.

I received the Benefit Programs Booklet **YES ( ) NO ( )** **MEDICAID APPLICANTS**: I received the Medicaid Handbook **YES ( ) NO ( )**

TANF APPLICANTS: The diversionary assistance program was explained to me. **YES ( ) NO ( )**
The family cap provision was explained to me. **YES ( ) NO ( )**

I filled in this application myself. **YES ( ) NO ( )** If **NO**, it was read back to me when completed. **YES ( ) NO ( )**

APPLICANT'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE OR MARK	DATE	SPOUSE'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE OR MARK (NOT NEEDED FOR FOOD STAMPS)	DATE
WITNESS TO MARK OR INTERPRETER	DATE	WORKER'S SIGNATURE	DATE

Complete the box below if this application was completed for the applicant by someone else.

NAME OF PERSON COMPLETING APPLICATION	DATE	ADDRESS
PHONE NUMBER (HOME) (WORK)		REALATIONSHIP TO APPLICANT